SECTION 4
MEDICARE CROSSOVER CLAIMS

Medicare/Medicaid (crossover) claims that do not cross automatically from Medicare to Medicaid must now be filed through the Medicaid billing Web site at www.emomed.com or through the 837 electronic claim transaction. This requirement became effective July 1, 2005. Before filing an electronic crossover claim, please wait sixty (60) days from the date of your Medicare payment to avoid possible duplicate payments from Medicaid.

There are two primary reasons claims do not cross over electronically from Medicare to Medicaid. One is because Medicaid enrolled providers have not provided Medicaid with their Medicare provider number or have provided an invalid or inactive Medicare provider number. If the provider has any doubt as to what Medicare number(s) is (are) on file, contact the Provider Enrollment Unit by e-mail at providerenrollment@dss.mo.gov. If you have not submitted your Medicare provider number to Medicaid, you can fax a copy of the Medicare letter showing the Medicare provider name and the assigned Medicare provider number along with a cover letter explaining why the information is being submitted to the enrollment unit. Provider Enrollment's fax number is (573) 526-2054. Please be certain to include your Medicaid provider name and number with any correspondence sent to Provider Enrollment.

Another reason claims do not cross over electronically is due to invalid patient information. Claims will not cross over electronically if the patient is not going by the same name with Medicare as they do with Medicaid. Additionally, the patient's Medicare Health Insurance Claim (HIC) number in the Medicaid eligibility file must agree with the HIC number used by the provider to submit the claim to Medicare. It is the responsibility of the patient to keep this information updated with their Family Support Division caseworker.

Following are tips to assist you in successfully filing a Medicare CMS-1500 Part B Crossover on the Medicaid billing Web site:

- Enter the information in the fields on the screen exactly as you did on your Medicare billing with the exception of the patient's name. The patient's name must be entered as it currently appears in the Medicaid eligibility file, not necessarily the name as shown on the Medicare remittance advice.
- There are HELP screens at the bottom of each screen page to provide instructions for completing the crossover claim screens, the "Other Payer" header and the "Other Payer" detail screens. Print each HELP screen in its entirety for reference when completing claims on the Internet.
- There must be an "Other Payer" header screen completed for every crossover claim. This provides information pertaining to the whole claim.

- There will be no group codes, reason codes or adjustment amounts entered on this screen for Part B claims.
- Completion of an "Other Payer" detail screen form is required for each claim detail line. The five (5) codes that can be entered in the "Group Code" field on the "Other Payer" detail screen form are in a drop down box, you need to choose the appropriate code. As an example, the "PR" (patient responsibility) code is assigned for Medicare coinsurance and/or deductible amounts from your Medicare remittance advice.
- The codes to enter in the "Reason Code" field on the "Other Payer" detail screen form are also found on your Medicare remittance advice. If not listed, you must choose the most appropriate code from the list of "Claim Adjustment Reason Codes". The HIPAA code lists can be accessed at the DMS home page, www.dss.mo.gov/dms. Click on the "Providers" link at the top of the page then click on the HIPAA-related Code Lists link found in the Provider Quick Links box.
- The "Adjust Amount" should reflect any amount not paid by Medicare including deductible, coinsurance and any non-allowed amounts.
- If there is commercial insurance payment or denial to report on the crossover claim, you must complete an additional "Other Payer" header form. You must also complete an additional "Other Payer" detail form(s) if the commercial carrier provided detail line information for line item payments and denials.

TIMELY FILING

Claims initially filed with Medicare within Medicare timely filing requirements and require separate filing of a crossover claim to Medicaid must meet the Medicaid timely filing guidelines for Medicare/Medicaid claims. The crossover claim must be submitted by the provider and received by the Medicaid agency within 12 months from the date of service or six months from the date on the provider's Medicare Explanation of Medicare Benefits (EOMB), whichever is later. *The counting of the six-month period begins with the date of adjudication of the Medicare payment and ends with the date of receipt.*

ADJUSTMENTS

If Medicare adjusts a claim and Medicaid has paid the original crossover claim, then the original claim payment from Medicaid must be adjusted through the Medicaid billing Web site. The "Claim Frequency Type Code" must be either a replacement (7) or a void (8). When submitting a replacement or void, the ICN (internal control number) being replaced or voided must be stated in the "Resubmission Ref. No." field. For a void claim, the only fields required for submission are the Patient Name, Patient Medicaid ID and the Resubmission Reference Number.

A sample of the Medicare CMS 1500 Part B Crossover is displayed on the following pages.

PALMETTO GBA - RAILROAD MEDICARE
P.O. BOX 10066
AUGUSTA, GA 30999-0001
1-877-288-7600

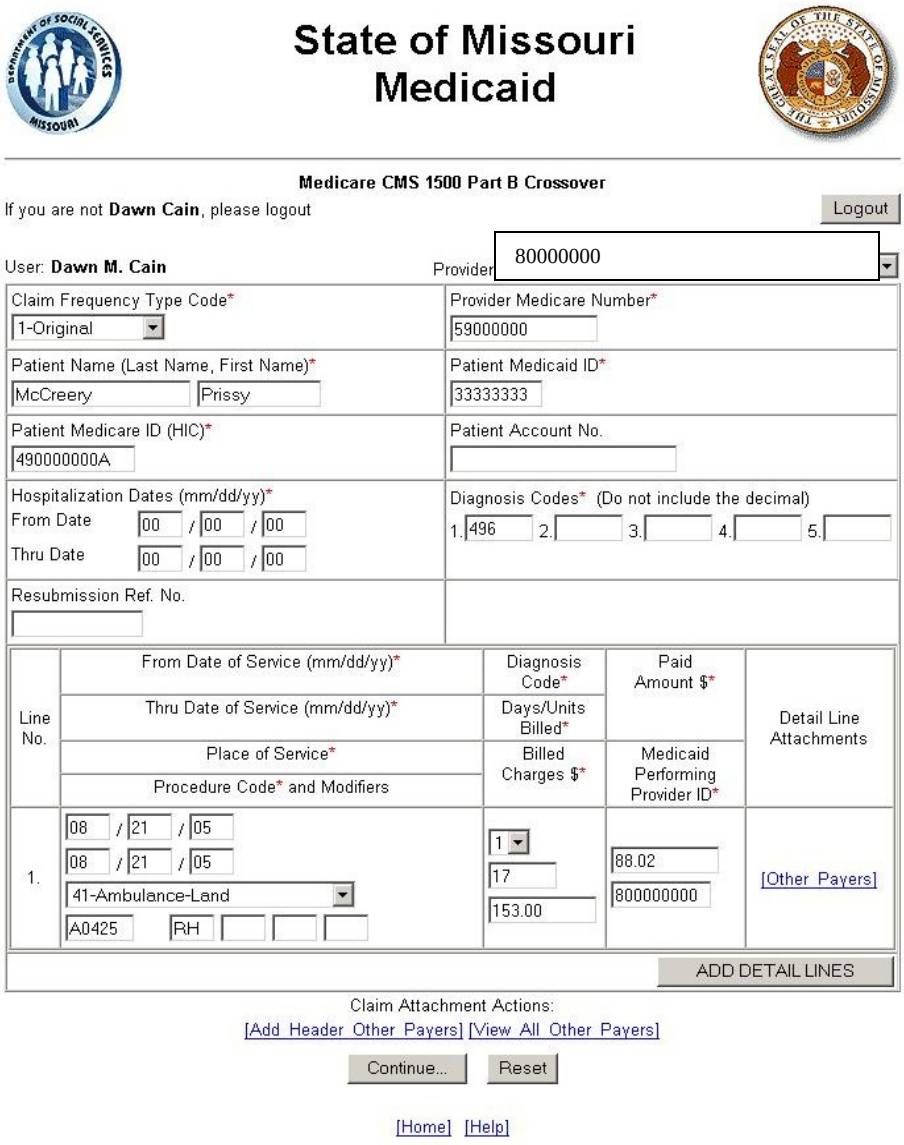
MEDICARE
REMITTANCE
NOTICE

PROVIDER: 59000000
PAGE #: 1 OF 1
DATE: 09/01/05
CHECK/EFT #: 103XXXXXX

ACME AMBULANCE DISTRICT
P.O. BOX 3XY
HOMETOWN, MO 650X8

PERF PROV.	SERV DATE	POS	NOS	PROC	MODS	BILLED	ALLOWED	DEDUCT	COINS	GRP/RC-AMT	PROV PD
NAME: MC CREERY, PRISSY		HIC: 490000000A				ACNT:		ICN 2400000000000		ASG Y HOA HA01	HA18
590000000	0821 082105	41	17	A0425	RH	153.00	110.03	0.00	22.01 CO-42	42.97	88.02
590000000	0821 082105	41	1	A0427	RH	475.00	328.87	0.00	65.77 CO-42	146.13	263.10
PT RESP	87.78			CLAIM TOTALS		628.00	438.90	0.00	87.78	189.10	351.12
CLAIM INFORMATION FORWARD TO: MO STATE MEDICAL CARE											351.12 NET

- **Using this example of a Medicare EOB, the following pages will guide you step-by-step through the process to file your Crossover Claim through the Medicaid billing Web site at www.emomed.com to collect the Medicare deductible and/or coinsurance amounts.**



State of Missouri
Medicaid

Medicare CMS 1500 Part B Crossover

If you are not **Dawn Cain**, please logout — Logout

User: **Dawn M. Cain** — Provider: 80000000

Claim Frequency Type Code*: 1-Original	Provider Medicare Number*: 59000000
Patient Name (Last Name, First Name)*: McCreery, Prissy	Patient Medicaid ID*: 33333333
Patient Medicare ID (HIC)*: 490000000A	Patient Account No.:
Hospitalization Dates (mm/dd/yy)*: From Date 00/00/00, Thru Date 00/00/00	Diagnosis Codes* (Do not include the decimal): 1. 496 2. 3. 4. 5.
Resubmission Ref. No.:	

Line No.	From Date of Service (mm/dd/yy)* / Thru Date of Service (mm/dd/yy)*	Place of Service* / Procedure Code* and Modifiers	Diagnosis Code* / Days/Units Billed*	Billed Charges $*	Paid Amount $* / Medicaid Performing Provider ID*	Detail Line Attachments
1.	08/21/05 – 08/21/05	41-Ambulance-Land; A0425 RH	1 / 17	153.00	88.02 / 800000000	[Other Payers]

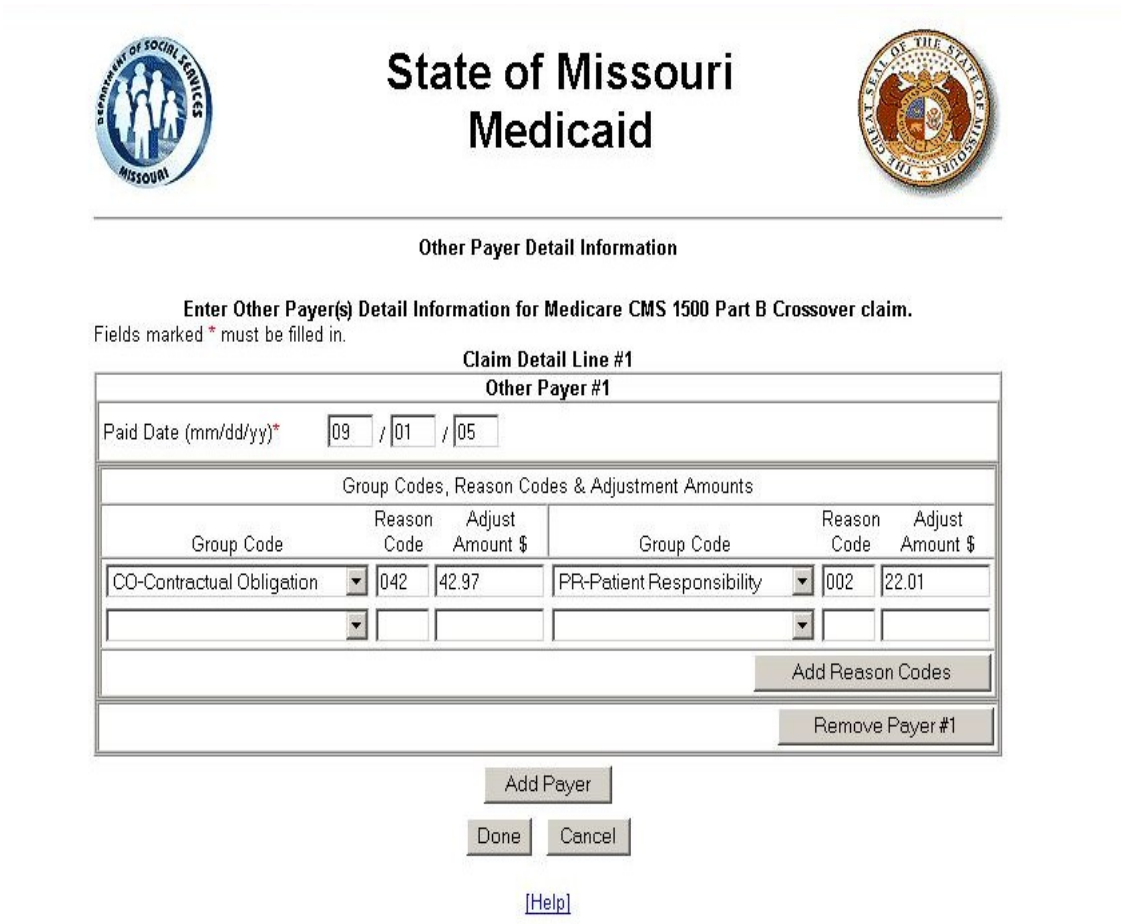
ADD DETAIL LINES

Claim Attachment Actions:
[Add Header Other Payers] [View All Other Payers]

Continue... Reset

[Home] [Help]

- **At the Medicaid billing Web site, click on "Medicare CMS 1500 Part B Crossover". This brings you to the above screen. Scroll to the bottom and click on the "Help" button, print and save the instructions.**
- **Complete the information on this screen as shown above using the Medicare EOB. Complete all fields with an asterisk through the first line item detail. Once the first line item has been completed, click on "Other Payers".**



State of Missouri
Medicaid

Other Payer Detail Information

Enter Other Payer(s) Detail Information for Medicare CMS 1500 Part B Crossover claim.
Fields marked * must be filled in.

Claim Detail Line #1

Other Payer #1

Paid Date (mm/dd/yy)* 09 / 01 / 05

Group Codes, Reason Codes & Adjustment Amounts

Group Code	Reason Code	Adjust Amount $	Group Code	Reason Code	Adjust Amount $
CO-Contractual Obligation	042	42.97	PR-Patient Responsibility	002	22.01

Add Reason Codes

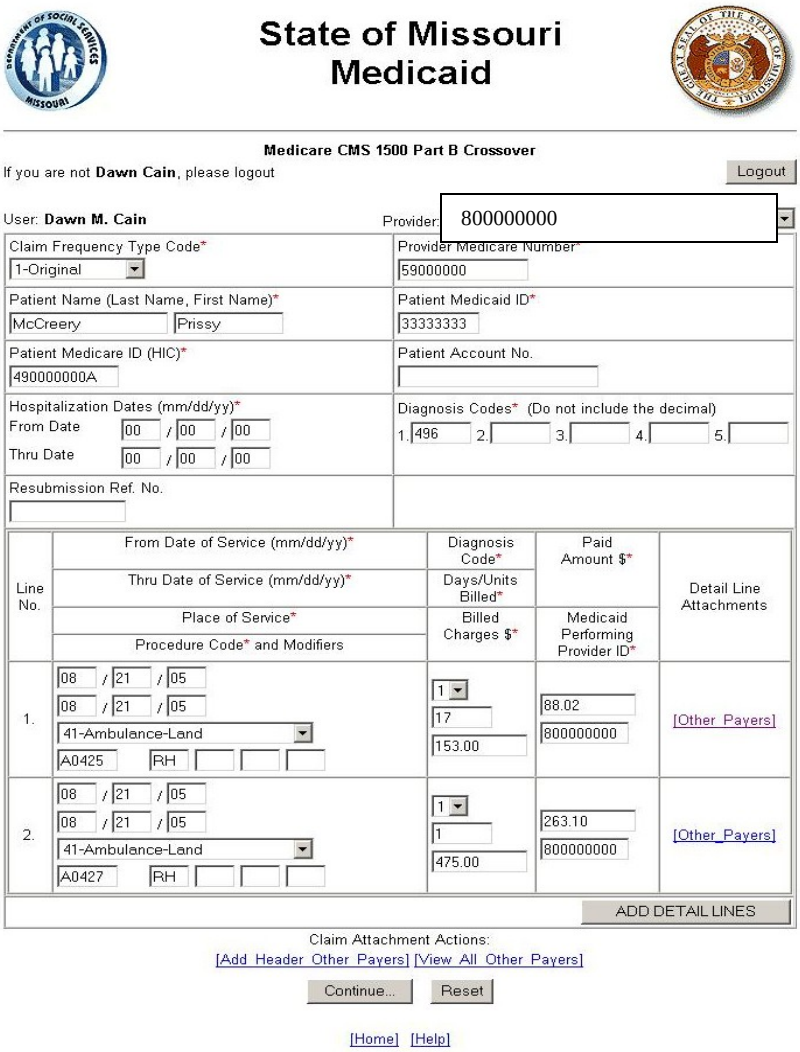
Remove Payer #1

Add Payer

Done Cancel

[Help]

- **This is the Other Payer Detail Screen. You must complete an Other Payer Detail screen for each line item of your claim. Scroll to the bottom and click on the "Help" button, print and save the instructions.**
- **Scroll back to the top, complete the Medicare paid date information as well as the Group and Reason Codes and Adjustment amounts for line #1. If the reason codes are not listed on your Medicare EOB, choose the most appropriate code(s) from the list of "Claim Adjustment Reason Code" from the HIPAA Related Code List. For example, the code on the "Claim Adjustment Reason Code" list for deductible is 1; for coinsurance the code is 2. You would then enter a Reason Code of 001 for deductible amounts and Reason code 002 for coinsurance amounts. In the above example, the provider should report CO-42 and $42.97 as shown on the sample EOMB for line 1.**
- **The "Adjust Amount" should reflect any amount not paid by Medicare including deductible, coinsurance and any non-allowed amounts. When finished, click "Done" to return to the original screen.**



State of Missouri
Medicaid

Medicare CMS 1500 Part B Crossover

If you are not **Dawn Cain**, please logout — Logout

User: **Dawn M. Cain** — Provider: 800000000

Claim Frequency Type Code*: 1-Original	Provider Medicare Number*: 59000000
Patient Name (Last Name, First Name)*: McCreery, Prissy	Patient Medicaid ID*: 33333333
Patient Medicare ID (HIC)*: 490000000A	Patient Account No.:
Hospitalization Dates (mm/dd/yy)*: From Date 00/00/00, Thru Date 00/00/00	Diagnosis Codes* (Do not include the decimal): 1. 496 2. 3. 4. 5.
Resubmission Ref. No.:	

Line No.	From Date of Service (mm/dd/yy)* / Thru Date of Service (mm/dd/yy)* / Place of Service* / Procedure Code* and Modifiers	Diagnosis Code* / Days/Units Billed* / Billed Charges $*	Paid Amount $* / Medicaid Performing Provider ID*	Detail Line Attachments
1.	08/21/05 – 08/21/05 – 41-Ambulance-Land – A0425 RH	1 / 17 / 153.00	88.02 / 800000000	[Other Payers]
2.	08/21/05 – 08/21/05 – 41-Ambulance-Land – A0427 RH	1 / 1 / 475.00	263.10 / 800000000	[Other Payers]

ADD DETAIL LINES

Claim Attachment Actions:
[Add Header Other Payers] [View All Other Payers]

Continue... Reset

[Home] [Help]

- **When you are back on the original screen, click on "Add Detail Lines" to add additional line items. Enter the information from each additional line from your Medicare EOB. After entering the data on the screen, click on "Other Payers" to get a new screen for "Claim Detail Line #2".**

State of Missouri
Medicaid

Other Payer Detail Information

Enter Other Payer(s) Detail Information for Medicare CMS 1500 Part B Crossover claim.
Fields marked * must be filled in.

Claim Detail Line #2

Other Payer #1

Paid Date (mm/dd/yy)* 09 / 01 / 05

Group Codes, Reason Codes & Adjustment Amounts

Group Code	Reason Code	Adjust Amount $	Group Code	Reason Code	Adjust Amount $
CO-Contractual Obligation	042	146.13	PR-Patient Responsibility	002	65.77

Add Reason Codes

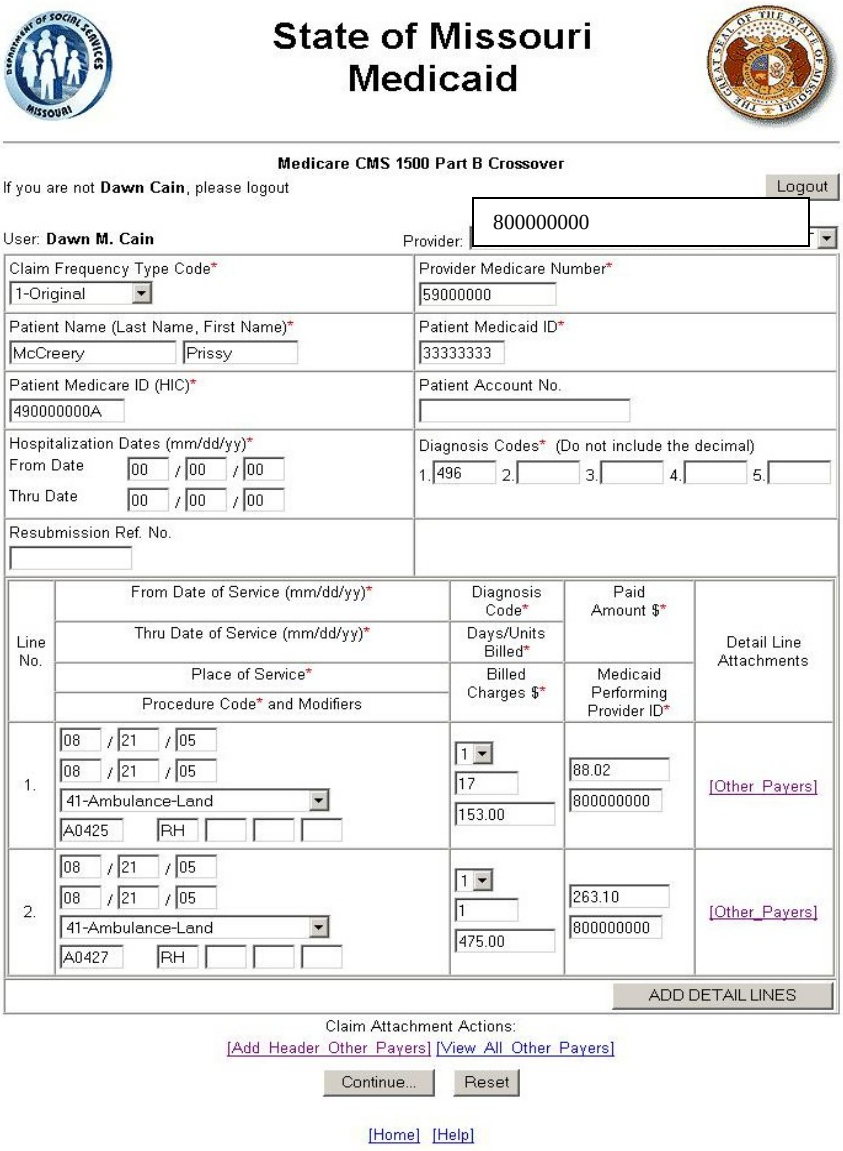
Remove Payer #1

Add Payer

Done Cancel

[Help]

- **For each line item from your Medicare EOB, you must enter an "Other Payer Detail Screen".**
- **The above is an example of the detail entry for line 2 showing both contractual and patient responsibility codes and amounts.**
- **When finished entering the claim detail information, click "Done" to return to the original screen.**



State of Missouri
Medicaid

Medicare CMS 1500 Part B Crossover

If you are not **Dawn Cain**, please logout — Logout

User: **Dawn M. Cain** — Provider: 800000000

Claim Frequency Type Code*: 1-Original	Provider Medicare Number*: 59000000
Patient Name (Last Name, First Name)*: McCreery, Prissy	Patient Medicaid ID*: 33333333
Patient Medicare ID (HIC)*: 490000000A	Patient Account No.:
Hospitalization Dates (mm/dd/yy)*: From Date 00/00/00, Thru Date 00/00/00	Diagnosis Codes* (Do not include the decimal): 1. 496 2. 3. 4. 5.
Resubmission Ref. No.:	

Line No.	From Date of Service (mm/dd/yy)* / Thru Date of Service (mm/dd/yy)* / Place of Service* / Procedure Code* and Modifiers	Diagnosis Code* / Days/Units Billed* / Billed Charges $*	Paid Amount $* / Medicaid Performing Provider ID*	Detail Line Attachments
1.	08/21/05 – 08/21/05 – 41-Ambulance-Land – A0425 RH	1 / 17 / 153.00	88.02 / 800000000	[Other Payers]
2.	08/21/05 – 08/21/05 – 41-Ambulance-Land – A0427 RH	1 / 1 / 475.00	263.10 / 800000000	[Other Payers]

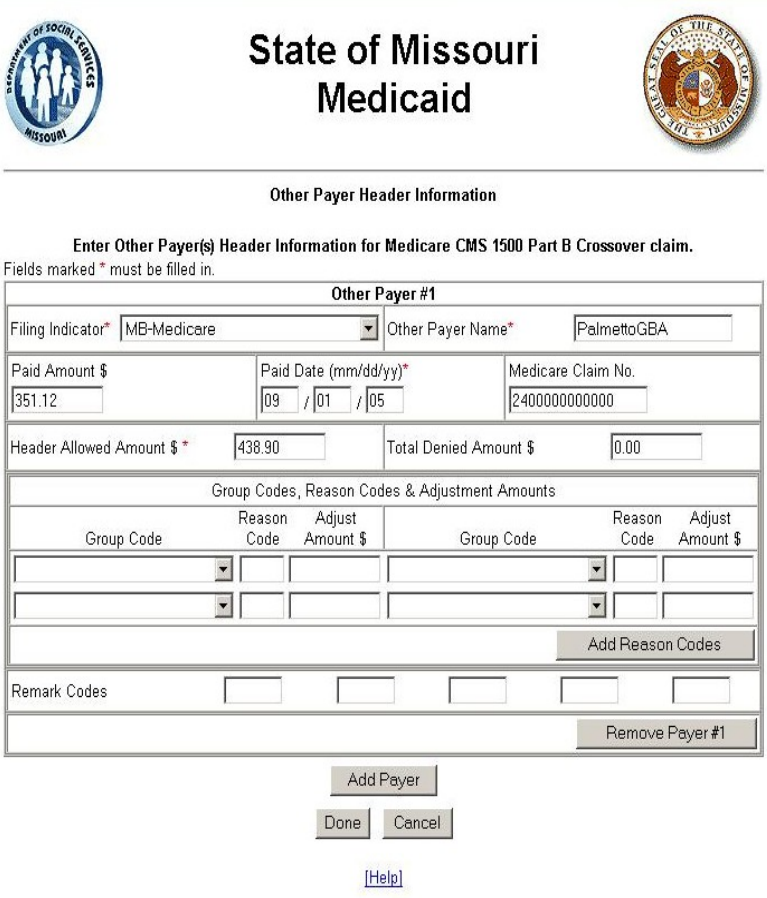
ADD DETAIL LINES

Claim Attachment Actions:
[Add Header Other Payers] [View All Other Payers]

Continue... Reset

[Home] [Help]

- **At this point you have completed each detail line from your Medicare EOB and an "Other Payer" screen for each detail line. Click on "Add Header Other Payers".**



State of Missouri
Medicaid

Other Payer Header Information

Enter Other Payer(s) Header Information for Medicare CMS 1500 Part B Crossover claim.

Fields marked * must be filled in.

Other Payer #1

Filing Indicator* MB-Medicare | Other Payer Name* PalmettoGBA

Paid Amount $ 351.12 | Paid Date (mm/dd/yy)* 09 / 01 / 05 | Medicare Claim No. 2400000000000

Header Allowed Amount $ * 438.90 | Total Denied Amount $ 0.00

Group Codes, Reason Codes & Adjustment Amounts

Group Code	Reason Code	Adjust Amount $	Group Code	Reason Code	Adjust Amount $

Add Reason Codes

Remark Codes

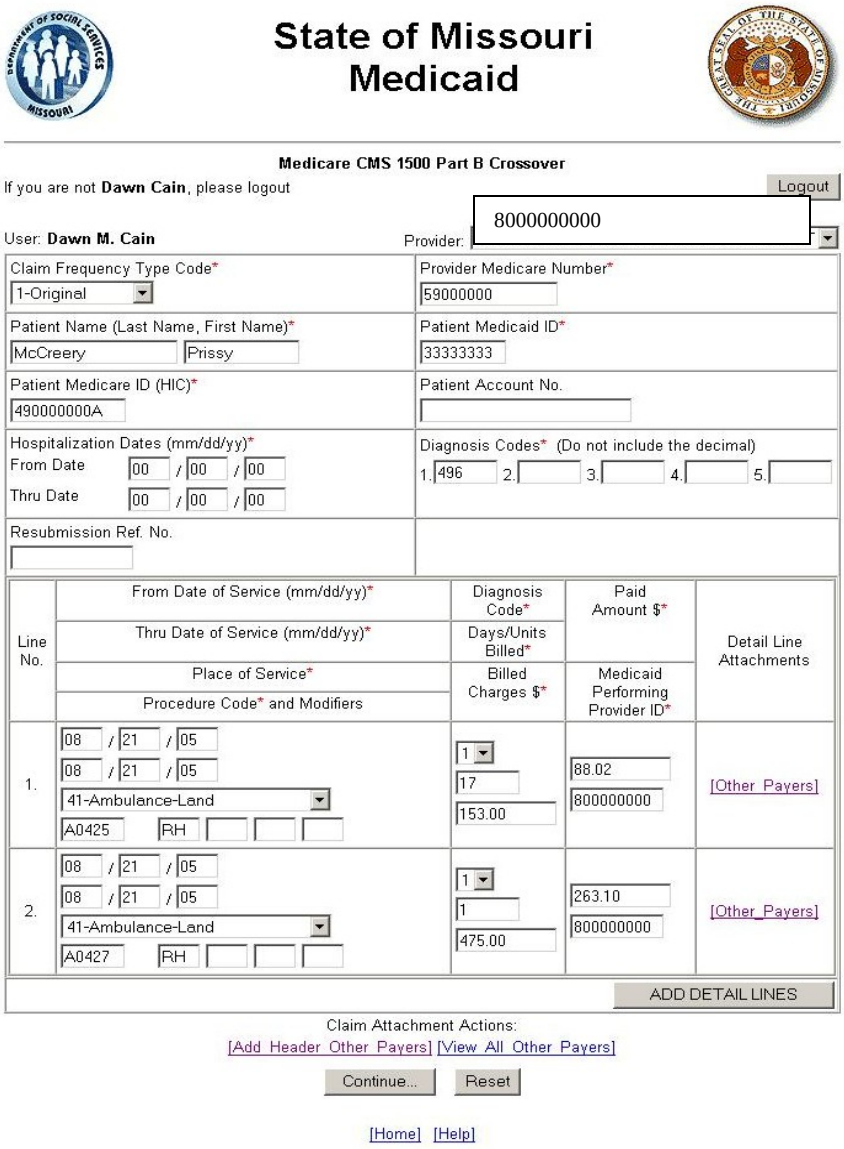
Remove Payer #1

Add Payer

Done Cancel

[Help]

- **You are now on the "Other Payer Header" screen. Scroll down to the bottom of the screen and click on the "Help" button, print and save the instructions.**
- **Scroll back to the top of the form and complete the information as shown. For Part B crossover claims, you do not complete the Group Codes, Reason Codes and Adjustment Amounts information. The Header Allowed Amount will always be the last field you will complete on the "Other Payer Header" screen. When completed, click on "Done" to return to the previous page.**



State of Missouri
Medicaid

Medicare CMS 1500 Part B Crossover

If you are not **Dawn Cain**, please logout — Logout

8000000000

User: **Dawn M. Cain** Provider:

Claim Frequency Type Code*: 1-Original	Provider Medicare Number*: 59000000
Patient Name (Last Name, First Name)*: McCreery, Prissy	Patient Medicaid ID*: 33333333
Patient Medicare ID (HIC)*: 490000000A	Patient Account No.:
Hospitalization Dates (mm/dd/yy)*: From Date 00/00/00, Thru Date 00/00/00	Diagnosis Codes* (Do not include the decimal): 1. 496 2. 3. 4. 5.
Resubmission Ref. No.:	

Line No.	From Date of Service (mm/dd/yy)* / Thru Date of Service (mm/dd/yy)* / Place of Service* / Procedure Code* and Modifiers	Diagnosis Code* / Days/Units Billed* / Billed Charges $*	Paid Amount $* / Medicaid Performing Provider ID*	Detail Line Attachments
1.	08/21/05 – 08/21/05 – 41-Ambulance-Land – A0425 RH	1 / 17 / 153.00	88.02 / 800000000	[Other Payers]
2.	08/21/05 – 08/21/05 – 41-Ambulance-Land – A0427 RH	1 / 1 / 475.00	263.10 / 800000000	[Other Payers]

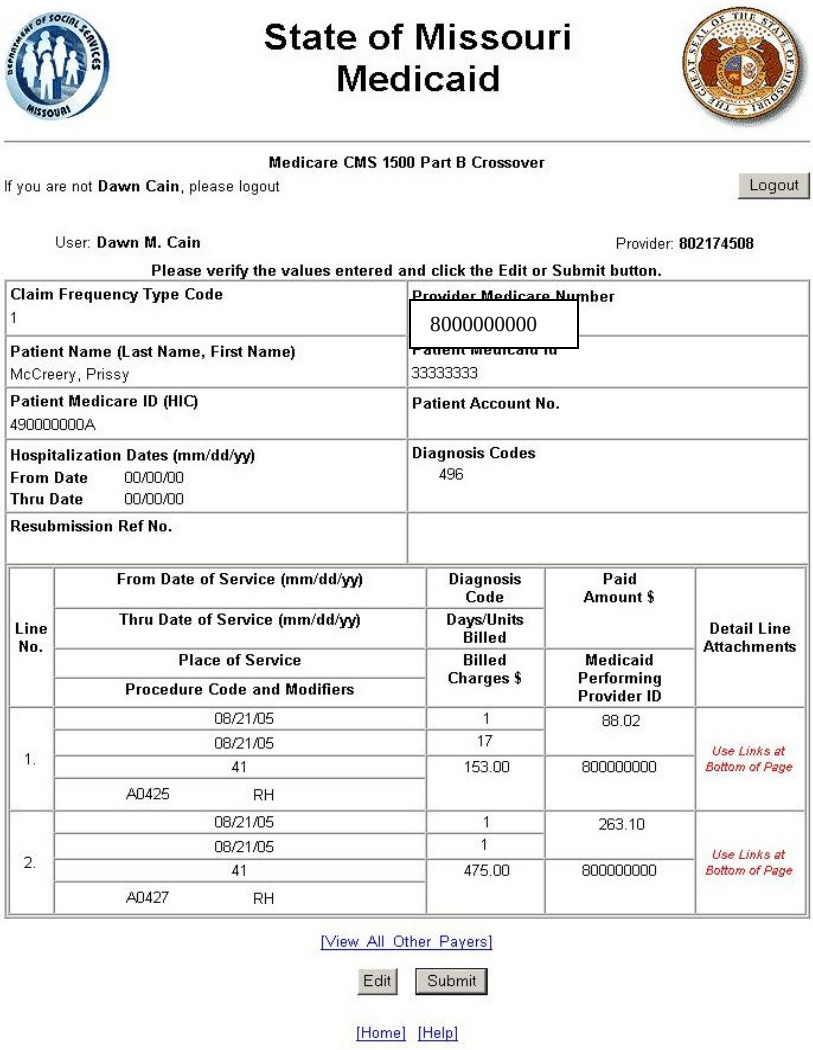
ADD DETAIL LINES

Claim Attachment Actions:
[Add Header Other Payers] [View All Other Payers]

Continue... Reset

[Home] [Help]

- **At this point all line detail information, Other Payers and the Header Other Payer has been entered. Click on "Continue".**



State of Missouri
Medicaid

Medicare CMS 1500 Part B Crossover

If you are not **Dawn Cain**, please logout — Logout

User: **Dawn M. Cain** Provider: **802174508**

Please verify the values entered and click the Edit or Submit button.

Claim Frequency Type Code 1	**Provider Medicare Number** 8000000000
Patient Name (Last Name, First Name) McCreery, Prissy	**Patient Medicaid Id** 33333333
Patient Medicare ID (HIC) 490000000A	**Patient Account No.**
Hospitalization Dates (mm/dd/yy) **From Date** 00/00/00 **Thru Date** 00/00/00	**Diagnosis Codes** 496
Resubmission Ref No.	

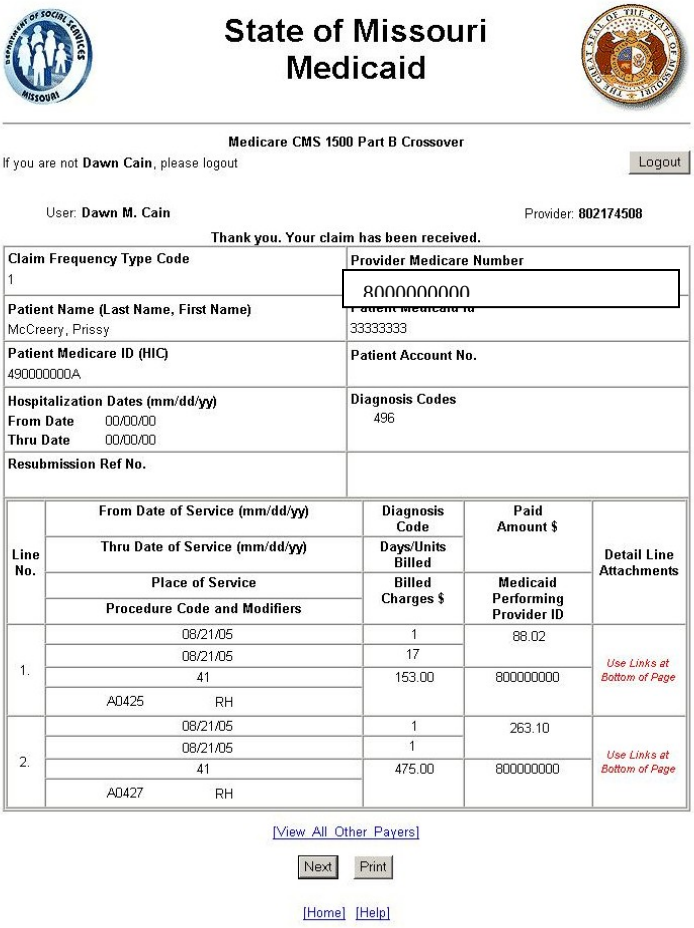
Line No.	From Date of Service (mm/dd/yy) / Thru Date of Service (mm/dd/yy) / Place of Service / Procedure Code and Modifiers	Diagnosis Code / Days/Units Billed / Billed Charges $	Paid Amount $ / Medicaid Performing Provider ID	Detail Line Attachments
1.	08/21/05 08/21/05 41 A0425 RH	1 17 153.00	88.02 800000000	Use Links at Bottom of Page
2.	08/21/05 08/21/05 41 A0427 RH	1 1 475.00	263.10 800000000	Use Links at Bottom of Page

[View All Other Payers]

Edit Submit

[Home] [Help]

- **You are now on the screen to verify the information entered. Scroll to the bottom of the screen and click "Help", print and save the instructions.**
- **You can either edit the information or submit. Click on "Submit" if all information is accurate.**



State of Missouri
Medicaid

Medicare CMS 1500 Part B Crossover

If you are not **Dawn Cain**, please logout [Logout]

User: **Dawn M. Cain** Provider: **802174508**

Thank you. Your claim has been received.

Claim Frequency Type Code 1	**Provider Medicare Number** 8000000000
Patient Name (Last Name, First Name) McCreery, Prissy	**Patient Medicaid Id** 33333333
Patient Medicare ID (HIC) 490000000A	**Patient Account No.**
Hospitalization Dates (mm/dd/yy) **From Date** 00/00/00 **Thru Date** 00/00/00	**Diagnosis Codes** 496
Resubmission Ref No.	

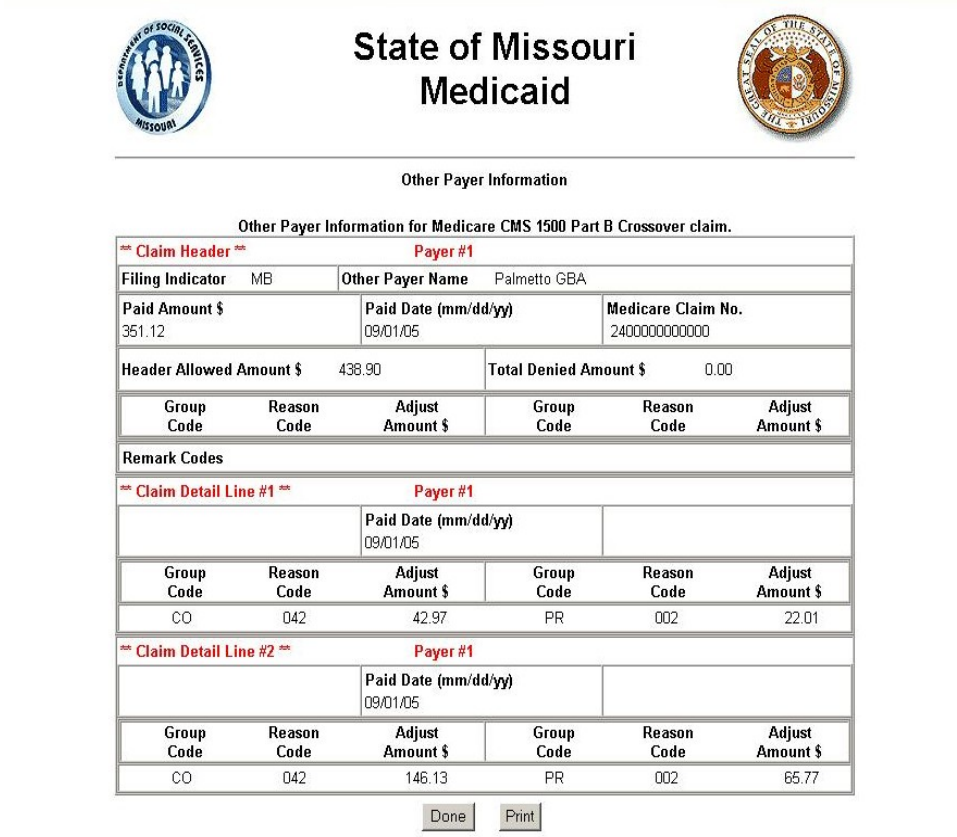
Line No.	From Date of Service (mm/dd/yy) Thru Date of Service (mm/dd/yy) Place of Service Procedure Code and Modifiers	Diagnosis Code Days/Units Billed Billed Charges $	Paid Amount $ Medicaid Performing Provider ID	Detail Line Attachments
1.	08/21/05 08/21/05 41 A0425 RH	1 17 153.00	88.02 800000000	Use Links at Bottom of Page
2.	08/21/05 08/21/05 41 A0427 RH	1 1 475.00	263.10 800000000	Use Links at Bottom of Page

[View All Other Payers]

[Next] [Print]

[Home] [Help]

- **After submitting your claim, you will be brought to a screen which states, "Thank you. Your claim has been received". You may click on the "Print" button at the bottom of the screen to print and save this page for your records.**
- **Click on "View All Other Payers".**



State of Missouri
Medicaid

Other Payer Information

Other Payer Information for Medicare CMS 1500 Part B Crossover claim.

** Claim Header **		Payer #1			
Filing Indicator MB		Other Payer Name Palmetto GBA			
Paid Amount $ 351.12		Paid Date (mm/dd/yy) 09/01/05		Medicare Claim No. 2400000000000	
Header Allowed Amount $ 438.90			Total Denied Amount $ 0.00		
Group Code	Reason Code	Adjust Amount $	Group Code	Reason Code	Adjust Amount $
Remark Codes					
** Claim Detail Line #1 **		Payer #1			
		Paid Date (mm/dd/yy) 09/01/05			
Group Code	Reason Code	Adjust Amount $	Group Code	Reason Code	Adjust Amount $
CO	042	42.97	PR	002	22.01
** Claim Detail Line #2 **		Payer #1			
		Paid Date (mm/dd/yy) 09/01/05			
Group Code	Reason Code	Adjust Amount $	Group Code	Reason Code	Adjust Amount $
CO	042	146.13	PR	002	65.77

Done Print

- **You can click on "Print" to save the Claim Header and Claim Detail for your records.**
- **Clicking on "Done" will take you back to the previous screen where you can either go back to the emomed home page or click on "Next" to enter a new claim.**